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ABSTRACT

A group process approach to community involvement in community based mental health services is discussed. There are numerous difficulties involved in attempting to establish meaningful and effective community participation including program complexities, and interpersonal and staff complexities. It is suggested that to effectively approach problems associated with community participation and control, it is important to consider developmental processes in community participation. The mental health professional should begin by establishing contact with a small group of community people who have an interest in community based mental health services. This total group should then become involved in a process similar to the stages of a task oriented group. The community group should be encouraged to move toward wider representation so that an adequate base can be established for active citizen participation. This organism can be strengthened and further developed through additional group process which emphasize: (1) availability-visibility; (2) flexibility; (3) openness; and (4) initiation of contact. (RSM)

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COMMUNITY INVOLVEMENT IN COMMUNITY-BASED MENTAL HEALTH SERVICES: A GROUP PROCESS APPROACH*

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BACKGROUND

Community control versus professional control is one of the most conflict ridden, emotionally consuming and uncertain areas in community mental health. The locus of control of mental health services is frought with an abundance of fear, confusion, rhetoric, rigidity and militancy. As suggested by Deschin[2], there are no easy approaches to the development of community control, and the issue of control of mental health services rests on exceptionally complex processes. Some form of community control of mental health services is inevitable, but in moving toward it, strong resistances from professional, political and community quarters are certain to arise. The road toward community control or even informed, vigorous and challenging community participation is always laden with much conflict and difficulty as indicated by Aronowitz.[1]

In the conflict and confusion attendant upon community versus professional control, another basic and vital issue is in danger of becoming obscured. This is responsibility for and competence to deliver quality mental health services at a community level.

Responsibility and competence are associated with sound and open administration, a firm and consistent advocacy for community mental health in all quarters of potential ignorance or resistance, a flexible and innovative attitude toward what constitutes community mental health, and joint accountability to the recipients of service, the community, and the body which has fiscal control of the mental health service. Factors associated with responsibility and competence are not vested exclusively in mental health professionals or community participants in mental health services. If responsibility and competence are understood and emphasized, they lead to readily available, socially relevant, effective mental health services in which the community has a proprietary interest.

There is no magic by which responsibility and competence for community mental health services can be achieved by merely vesting control in either mental health professionals or community participants. To do this represents an arbitrary, insensitive decision which can only lead to continued conflict. One wonders, why such non-productive conflict is courted, unless it is an attempt to keep the mental health professional and community participant from developing a strong, interdependent, openly acknowledged relationship, regardless of where the control may ultimately lay. Such a relationship promotes responsibility and competence, and is effective in building community-based mental health services, in educating the mental health professional and community participant, and assisting both in developing a sense of mutual trust and respect.[3,4] Such an interdependent relationship is also highly effective in dealing with the resistances to community-based mental health services encountered in professional, political and community quarters.

IDENTIFICATION OF THE COMMUNITY AND THE STATUS OF MENTAL HEALTH SERVICES

One of the most difficult tasks confronting anyone with genuine interest in community mental health services is meaningful and effective participation of the community. There is no easy path to this participation regardless of the degree of community involvement which is sought or which develops. From a mental health viewpoint there is no easy way to define who represents the community, be he called a consumer, a user, a caretaker, an indigenous representative, a patient, a participant, or simply a resident. From a mental health viewpoint, community implies all such individuals and many others. Such diversity is particularly important if we regard

heterogeneity as healthy and as a potential mental health resource. While knowledge about community representation has developed rapidly during the past few years, there is yet much to learn about who represents a given community when referring to mental health services. It is vitally important that this subject be approached in a pragmatic and open manner on the part of all concerned. To quote Robert Frost, "...Before I built a wall I'd ask to know what I was walling in or walling out, and to whom I was like to give offense."

An equal number of problems are associated with the relative importance or status attached to mental health services compared with the many problems and needs which exist at the community level, particularly in the urban community. Mental health services in an urban setting are frequently regarded as part of general health and/or welfare services. Many view mental health services in the urban community as bearing a lower priority than such things as housing, employment, education and physical health. Yet mental health is inextricably related to these areas. Mental health workers and community participants are not always clear as to the over-all goals of community mental health, nor are they always able to articulate its close relationship to physical health, housing, employment and education.

Problems associated with the identification of community representation and the relative status of mental health services have significantly affected the type and degree of community involvement. These problems are certain to continue to affect the concept if not the pathway toward community control of mental health services.

COMPLEXITIES AND RESPONSIBILITIES ASSOCIATED WITH CONTROL

At this point in the community mental health movement it is apparent

that if a community mental health service is to approach adequacy and relevance, it must have maximum involvement of those it seeks to serve at all phases of planning, development and operation. To date, community involvement in mental health has ranged from a total absence of meaningful involvement to the beginnings of complete community control. However, in urban community mental health, citizen participation appears far stronger at the local level than at the municipal level.[5] From both mental health and community viewpoints, emphasis has been placed on control of the mental health operation. Insufficient emphasis has been placed on the complexities, responsibilities and problems associated with control of a community mental health service. It is not clear that one seeks control solely to promote mental health services, particularly when one experiences the complexities, problems and demands that attach to control. Complexities and responsibilities associated with control of a community mental health operation can arise in at least four major areas. There are no sharp distinctions among these four areas, and the specific examples offered are suggestive rather than exhaustive.

A. Administrative Complexities

Sound administration is intimately related to sound community mental health services. The value of sound administration has been underemphasized, and problems associated with administrative practices in community mental health have not always been clearly spelled out. The constraints in the administration of any community mental health operation are enormous, and are related to critical issues such as organizational structure, personnel policies and procedures, fiscal and budgetary operations, and decentralization and autonomy.

A clear understanding of the development and importance of organizational structure, including board structure is imperative for good administration. If this is not understood early in the development of the mental health operation, lack of clarity, indecisiveness and duplication characterize the administration, and weakness and mediocrity characterize the mental health service. Carefully developed organizational structure provides a clear understanding of who controls what, and who is accountable to whom. Sound organizational structure provides clear relationships among administrators, board or community participants, and staff providing the mental health service. A clearly delineated, implementable organizational structure assures smooth, consistent delivery of mental health services, regardless of the locus of control.

An associated administrative complexity concerns personnel policies and procedures. To provide an effective mental health service, staff must be clearly aware of responsibility and accountability to those in both superordinate and subordinate positions. In a more specific sense, staff must clearly understand who they work for as well as their entitlements. It may seem mundane, but clear procedures on factors such as health and accident insurance, vacation and sick leave, hours of work, timing of salary increments, etc. is extremely important. Not to ascribe importance to these matters assures poor operation of the mental health service. To clearly and sensitively interpret personnel policies and procedures promotes staff morale and cohesiveness, and ultimately, the mental health service.

A comforting illusion of the mental health administrator is that more money will invariably solve problems in administration or program. This illusion derives from a poor mastery of fiscal and budgetary operations. It is exceedingly important for example, to understand the difference between a

budget request and a budget. It is equally important to understand the development of a comprehensive budget request which maximizes staff and community participation, along with the presentation and justification of this request before a variety of bodies and individuals. Regardless of who controls the mental health operation, sound administration implies the development of realistic, clearly stated and thoroughly considered budget requests which can be readily translated into mental health services. Moreover, the mental health administrator must answer to many regarding budget requests and budget utilization: legislators, community participants, grant-in-aid bodies, health administrators, mental health staff, etc.

Insufficiency of mental health appropriations is also a frequent fear, but under-spending of actual mental health appropriations occurs easily, and may be more damaging to the mental health service than budgetary insufficiency. The mental health administrator may be tempted to voice frequent complaints about insufficient mental health appropriations or problems in utilizing existing appropriations. It can be easier to complain than to assure that available financial resources are utilized in the most effective and creative manner possible. Regardless of the locus of control, sound administration implies the latter condition which assuring that effective mental health services to the community served retain the highest priority.

A final administrative complexity concerns <u>decentralization and autonomy</u>. It has been suggested that control of the mental health operation has been emphasized rather than responsibility and competence in relation to mental health services. A simple corollary is that both mental health workers and community participants are people, subject to power and status needs, and with definite feelings about control. How the individual with ultimate

responsibility for mental health services approaches and utilizes control is of critical importance. Community mental health can only operate optimally at the community level if the many positive attributes of de-centralization are understood and maximized, and if the autonomy of the local mental health operation is emphasized. Excessive centralized control whether vested in the community participant or the mental health professional can only impede the delivery of community-based services and work serious damage on the mental health service.

B. Program Complexities

Program complexities involve such things as understanding differences between basic, necessary and existing mental health services, and anticipated or proposed services. Program complexities also imply the setting of intelligent priorities among a multitude of potential mental health programs, and the many mental health needs of the community to be served. Program responsibilities involve a clear understanding of the relationship between the community mental health service and other services within the same system. Sound program administration carries the additional responsibility of understanding potential relationships between the mental health service and other health or welfare services operating within the community served.

A word must be added about program effectiveness and evaluation. In any community mental health operation, programs must be evaluated and reviewed continually. There is no question that community residents or the recipients of the mental health service should have a major voice in the evaluation process. Whoever controls the mental health service however, must make ultimate decisions about which programs are to be emphasized or supported, which are to be modified, and which are to be abandoned. These decisions are certain to bring criticism and dissatisfaction.

C. Political Complexities

The body or agency which controls a community mental health operation has to contend with at least two political systems in addition to the staff. Complexities of control of a community mental health operation are related to the responsible governmental unit if it is publicly funded. The governmental unit constitutes a political system as it exists through an elective or legislative process. The type of governmental unit may vary greatly in organization, strength and commitment to welfare services, health, and ultimately community mental health.

The community to be served frequently constitutes a de facto political system, although the degree of community organization and political sophistication present varies greatly, particularly in urban communities. Control of a community mental health operation involves coming to grips with the political system which exists in the community to be served. Anyone who has spent time directing a community-based mental health operation knows the potency of community politics regardless of the sophistication which may attach to them. The complexities of community politics can be equally as difficult to master as the complexities of governmental politics. Moreover, the following events can occur in relation to both political systems: lack of interest in the community mental health service, power plays among factions of either political system in which the mental health service becomes a pawn, vested interests on the part of a few regarding a mental health development, and the subversion of the mental health advocacy through political strategies.

Whoever controls a community mental health operation must be prepared to deal with a variety of problems in relation to both political sources. No matter how sensitively the governmental agency or community system is worked

with, a consistent advocacy for mental health will alienate some and cause dissatisfaction with the mental health service. The controller of the mental health operation must continually fight for support, recognition, and an appropriate status for the mental health operation. In short, the controller of the mental health operation has to maintain a firm and consistent advocacy for community mental health in governmental quarters and community quarters regardless of the questions, opposition and problems which may arise. Whether employed by a public agency, a private agency or the community, the mental health professional with administrative responsibility would do well to bear in mind a comment from Edmund Burke. "Your representative owes you, not his industry only, but his judgment; and he betrays instead of serving you if he sacrifices it to your opinion."

D. Interpersonal and Staff Complexities

The body, agency or individual controlling a mental health service must make many decisions affecting issues as diverse as staff morale, promotions, salary raises, program assignment, attendance at conferences or seminars and so forth. These decisions may involve conflict, and are certain to displease some. For example, much emphasis has been placed on the right to hire and fire personnel assigned to a particular community. Authority to hire and fire personnel is thought to constitute one of the most important elements in the control of a mental health operation. Unfortunately at times, greater emphasis has tended to be placed on authority to fire personnel. Whoever controls the mental health operation must recognize that heavy and sober responsibilities accompany the hiring and firing of personnel. Individuals' livelihood and competence are directly at stake as contrasted with conjectures about program relevance and effectiveness.

THE DEVELOPMENT OF COMMUNITY PARTICIPATION
THROUGH GROUP PROCESSES

A. Early Developmental Stages

To effectively approach problems associated with community participation and control, it is important to consider developmental processes in community participation. Community participation usually has a beginning point. While it may occur spontaneously, it does not occur magically, and usually evolves through a developmental process. There are serious questions if meaningful community participation can occur through legislative acts or professional fiats. In developing community-based mental health services in Chicago, we have noticed at least three relatively well defined stages through which community participation evolves.

An urban community contains many potential mental health resources although it may not contain a formally organized mental health service. Community residents and institutions constitute an extremely important potential mental health resource. This suggests that a formal community organization process preceding the development of mental health services may imply a pejorative attitude toward the community's state of organization if not handled sensitively. Under such conditions the mental health professional begins his approach to the community as an expert, stating what the community needs, and ignoring the realities present and potential mental health resources. He approaches the community demographically rather than experientially.

Conversely, if the mental health professional approaches the community openly, seeking to learn about it and what he can do to help meet its mental health needs, he becomes engaged with the community in a significantly different manner. The mental health professional can usually establish contact with a group of three or four people in any community who have a strong

interest in community-based mental health services. Those comprising this nuclear group may be individuals such as a teacher, clergyman, policeman, youth worker, parent of an emotionally disturbed child, resident with an interest in mental health, or a member of a block club or community organization interested in community betterment.

After such a nuclear group has been identified, it is helpful to have it broaden its membership to fifteen or twenty participants, although any number chosen is arbitrary. This step is taken to develop broadened, active and informed community participation around the mental health enterprise. At this stage a group process has already begun, and the mental health person or persons involved, have become an integral part of this group process. The mental health person brings his mental health and administrative expertise to this group, but he quickly learns that he can apply this expertise only when asked to do so by the nuclear group. His main task is to relate to the nuclear group as a resource vital to the development of good community mental health services, and to foster, trust, and learn from its group processes. The mental health professional may attempt to accomplish this goal through such techniques as openness, availability and constancy. He can provide few specific answers to the questions and demands of nuclear group; he can provide only broad suggestions and directions. The mental health professional cannot assume the lead in this emerging group process; leadership and courses of action must emerge from the group.

The total group including the mental health professional becomes involved in a process with many similarities to the early formation and development of a task oriented group. In this stage of the group process,

there is a great deal of uncertainty, groping and frequent mistrust on the part of all participants. These attitudes may be accompanied by feelings of impotence and futility regarding tangible achievement, and occasional intra-group conflict. There are usually vested interests on the part of all participants, but as group cohesiveness grows, these vested interests usually become subordinate to the major group goals. As the group process develops, the group continues to gain in strength and works toward the common goal of community-based mental health services. This common goal constitutes a major reason for early group interaction, stability, cohesiveness and movement.

B. Later Developmental Stages

Early in its development the nuclear group should be encouraged to move toward wider community representation and increased size. Once this occurs, the group can be regarded as an ad hoc community planning group for mental health services. The original nuclear group has a vital role in assuring that the ad hoc planning group becomes a more broadly based, self-generating and self-sustaining group for mental health purposes. In short, group processes should continue, and the ad hoc planning group should reflect a wider and more heterogeneous composition. The operating efficiency and cohesiveness of the ad hoc planning group should also continue to increase. At about this point, the ad hoc group may begin to reflect a diminished need for the mental health person except as a special "consultant." The ad hoc group has developed solid information and ideas about community mental health as well as its own structure, activities and degree of influence. The ad hoc group should have sufficient structure, strength, cohesiveness and knowledge of mental health so it can operate effectively with community residents requiring the service, mental health staff providing the services, and local political leadership, as suggested by Rothstein.

To establish vigorous and informed community participation, further development through the group process is required. If community participation occurs to the level suggested above, a firm basis has been established for the mental health service to be strongly community related at its inception, if not before. If the group processes are brought to fruition, healthy community participation has been established, which assures meaningful and effective interaction with the mental health professionals on the scene. Another outcome of these developmental processes is the establishment of a proprietary interest in community mental health activities on the part of a strong, well integrated, increasingly sophisticated community group usually known as the board. Regardless of what this group is called, e.g., advisory board or board of directors, a basis has been established for strong and continuous community participation, and the mental health service is richer as a result of this developmental process. Consistent utilization of group processes in developing community participation usually increases the probability that the mental health service will be community oriented rather than professionally oriented.

C. Further Developments

If an adequate base has been established for active citizen participation leading to joint professional and community responsibility if not community control of the mental health operation, this base must be tested and developed beyond its formative stages. The mental health professional-citizen participant relationship which has developed along group process lines usually begins to be tested and modified as actual mental health services are delivered at the community level. This relationship is tested through a series of actions which may include a number of poor communications and confrontations. However, only after such testing, can its effectiveness

and the outcome of the early group process be determined.[7]

Much remains to be done in developing the professional-citizen or staff-community board relationship beyond these early stages. A continuation of the earlier group process is indicated, but it clearly emphasizes mutuality of effort, sharing of responsibility and determination of common goals. These developments constitute a two way street between mental health persons and community participants or community board, but the attitudes and actions of the mental health person remain crucial.

At this point the mental health worker-community participant or staff-board relationship is lodged in a continuous group process, and can be viewed as an operating organism. This organism can be strengthened and developed further through additional group processes which emphasize the following factors.

1. Availability-Visibility

Group process is usually assisted positively if the leader, consultant, convener, etc. is readily available. Translating this observation into the context of the mental health professional operating in a community setting, we note the following. The mental health professional must show a ready presence in the community via attendance at board meetings, open houses and other community activities related to mental health. He cannot always choose the time and location of his presence, and must be prepared to respond to the community when they feel that they need him. The mental health professional in a community setting might consider the following statement by Thomas Jefferson, "When a man assumes a public trust, he should consider himself as public property." The problem of availability can be highlighted by the issue of telephone calls. Calls to and from the

community participant may seem trivial, and at times irritating, but they signify and symbolize a great deal. They must be given the highest priority, and dealt with in an expeditious, open, straightforward manner.

2. Flexibility

The individual with experience in group process instinctively knows when to take cues from the group and when to follow its leadership and judgement. The mental health professional in a community setting is well advised to practice this approach. It is also important to remember that mental health professionals with clinical backgrounds have been trained extensively in the multi-faceted arts of listening and understanding. Appropriate utilization of these capacities assures that the mental health professional will usually hear what is being said by the community, regardless of the spokesman giving the message, and latent vested interests and power plays. In a group process context the community participant usually has much to offer, and the mental health professional always has much to learn.

3. Openness

Group process is frequently more potent than imagined, and many must learn to trust it. Thus community participants or board members must be fully informed at all times regardless of the type of information involved. Community participants must not be enlisted only at times of crisis as perceived by the mental health professional. Under this condition, the community participant is cast in the role of a fireman responding to conflagrations, and unfortunately may begin to perceive that he will only be responded to under such conditions. The mental health professional must strive to share all aspects of planning and action in addition to problems with the community participant, regardless of how minute they may appear. If he trusts group

process, he can accept the viewpoint that group process, as reflected in the mental health professional-community participant relationship, can be instrumental in resolving a broad spectrum of issues and problems far more effectively than the mental health professional alone.

4. Initiation of Contact

He who esteems group process, values the wisdom and strength of the group. In practical terms, the mental health professional should rarely wait for the community participant or board to initiate actions on issues vital to the mental health enterprise. There may be legitimate questions about the timing of sharing information, but there should be no question about whether or not to share information related to the mental health enterprise. The mental health professional must frequently assume the lead in initiating contact with the community participant or board on many issues. The community participant or board need accurate and adequate information if they are to participate intelligently in promoting the mental health enterprise.

D. Outcomes

There are a number of outcomes for community involvement in community-based mental health services through a group process approach. A highly interdependent relationship is created between mental health professional and community participant, regardless of the locus of control of the mental health operation. The development of this relationship implies that a mutual and healthy respect and trust develops between both parties, and that neither becomes deified by the other.

Another result of this interdependent relationship is a high degree of involvement and sophistication about mental health services and their

ramifications by community participants, and respect for the approaches and influence of community participants on the part of mental health professionals. Both community participants and mental health professionals gain a clearer picture of professional, political and community forces and realities affecting the mental health enterprise. These forces and realities can then be approached from a united position on the part of the community participant and mental health professional. A possible result of the group process approach is neither professional nor community control, but an interdependent relationship which suggests joint control of but also joint responsibility for the mental health service. Joint responsibility of community participant and mental health professional lends a great deal of vitality, flexibility and openness to the planning, development and delivery of community mental health services.

If mental health professionals do not want community participants as bedfellows, we should note that community participants may not want mental health professionals as bedfellows. However, a group process approach emphasizing shared effort and shared responsibility of mental health professional and community participant is an important approach in which community mental health can develop and operate, if not survive.

IMPLICATIONS

Problems associated with the identification of the community and the role of the mental health service have been reviewed, as have a range of complexities and responsibilities associated with control of a mental health service. In this review the issue of community versus professional control of the mental health service has not been faced directly. The locus of control appears to be an extremely emotional and perhaps misleading issue

which is extraordinarily difficult to resolve adequately. Excessive attention to the locus of control does little to resolve issues of responsibility and competence for effective community-based mental health services.

As a modification of the control issue, community participation has been related to a developmental approach which places heavy stress on group processes. If followed, this approach tends to assure vigorous, informed, proprietary community interest in the mental health enterprise based on mutual respect between the mental health professional and the community participant. Optimally, this approach avoids the rhetoric and non-productive struggles associated with professional versus community control. The result of the group process approach may be some form of joint community and professional control over the mental health service, but its quintessence is joint responsibility. Active promotion and utilization of mental health services at the community level is a major outcome of the highly interdependent relationship between community participant and mental health professional fostered by the group process approach. In addition to active and intelligent promotion of community mental health, this interdependent relationship has implications in at least four areas.

A. Implications for the Mental Health Professional

The mental health professional comes to recognize that clinical, technical and administrative skills by themselves are not sufficient to function in a community-based mental health setting. He learns that he needs community participants and their interest and support at least as much as they need him. Optimally, he learns to regard community participants as allies and peers, not as enemies and inferiors. If he forms a strong, openly acknowledged alliance with community participants, it is likely that he will provide more effective mental health services at the community level.

B. Implications for the Community Participant

Although many community participants may wish to "go it alone" and assert complete control over the local mental health service, open acknowledgement of interdependency with the mental health professional may give pause about this course. In view of complexities and responsibilities associated with control, this path may create additional problems, and still fail to provide adequate mental health services at the community level. As suggested by Reissman and Gartner[6], the quest for community control is a healthy development, but many dangers attach to it, and community control does not assure resolution of problems in the delivery of mental health services. The community participant requires not only the expertise of the mental health professional, but also his genuine committment to the promotion of the mental health service at the community level. When this occurs and the community participant openly recognizes his involvement in an alliance with the mental health professional, it is probable that the community participant becomes more knowledgeable and effective in his efforts on behalf of mental health.

C. Implications for the Mental Health Service

As a result of the high degree of community and professional interdependency, the community mental health service develops improved support in both community and professional quarters. Moreover, respect, trust, rapport and mutuality can be emphasized rather than competitiveness and divisiveness between mental health professional and community participant. There are many problems associated with community mental health; the mental health service has much to gain if mental health professionals and community participants present a united front and a unified approach to problems

affecting the community-based mental health service. If a unified approach to problems does not occur, considerable time and energy are wasted on struggles which are not always productive, and the mental health service at best will be mediocre, and perhaps may even cease to exist.

D. Implications for Bodies Providing Funds for Mental Health

Although the interdependent relationship between mental health professional and community participant may pose a threat to funding bodies such as state legislatures, city councils, NIMH, etc., it will also present them with a clearer, more unified understanding of both the problems and promises of community-based mental health services. If community mental health is to assume its rightful importance, it is imperative that bodies funding the mental health services receive information and evaluation from both mental health professionals and community participants so their judgements can have the wisdom of many.

CONCLUSIONS

1. Vigorous community participation in community mental health is essential if community mental health is to succeed. The quest for community control of mental health services is a healthy development, but many complexities and dangers are inherent in control. Moreover, the goal of community mental health is not control of the service, but effective, readily available, relevant mental health services for those who need them.

2. Some degree of community control over mental health services is inevitable, but in struggles related to the locus of control, responsibility for and competence to provide quality community-based mental health services should remain primary.

3. Strong, informed community participation in community mental health can be developed through a series of developmental stages emphasizing group processes. This approach leads to a highly interdependent relationship between community participant and mental health professional based on mutual trust and respect. Due to the nature of this relationship, joint responsibility for and joint control of the mental health enterprise are emphasized.

4. The mental health professional, the community participant and the mental health service all benefit from this interdependent relationship. Such an alliance provides greater strength and unity to positively resolve the struggles ahead for the growth, if not the survival of community mental health.

In a lighter vein, we might consider the definition of marriage offered by Ambrose Bierce:

"A community consisting of a master,
a mistress, and two slaves,
making in all, two."

REFERENCES

1. Aronowitz, S., 1970. The Dialetics of Community Control. Social Policy. 1:47-51.

2. Deschin, C., 1970. Community Control: Myth or Reality? American Journal of Orthopsychiatry. 40:740-743.

3. McGee, T.F., 1970. Illusion and Reality in Community Mental Health. Paper presented at the 47th annual meeting, American Orthopsychiatric Association, San Francisco, California.

4. McGee, T.F., and Wexler, S., 1970. The Evolution of Municipally Operated, Community-based Mental Health Services. Paper presented at the 46th annual meeting, American Orthopsychiatric Association, New York, New York.

5. McGee, T.F., and Wolfe, J. Patterns of Mental Health Development in Major American Cities. Community Mental Health Journa. (In press)

6. Reissman, F. and Gartner, A., 1970. Community Control and Radical Social Change. Social Policy. 1:52-55.

7. Rothstein, S., 1970. Community Mental Health in an Urban Setting: the Community-Advisory Board-Staff Relationship. Paper presented at the 97th annual forum of the National Conference on Social Welfare. Chicago, Illinois.